

Prime 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/13/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat Lumbar MRI

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

M.D., Board Certified Neurological surgery

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. The reviewer finds medical necessity does not exist at this time for Repeat Lumbar MRI.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Consultation note Dr. 02/13/12
MRI lumbar spine 01/25/11
Progress report Dr. 02/08/12
Progress note Dr. 03/08/12
Clinical follow up Dr. 03/19/12
Procedure report 03/09/12
Progress note Dr. 02/20/12
Progress report Dr. 03/28/12
Progress report Dr. 04/13/12
Progress report Dr. 05/09/12
Progress note Dr. 06/07/12
Progress report Dr. 07/05/12
Utilization review 04/26/12 and 07/10/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx. The patient has been followed for complaints of low back pain that has continued despite epidural steroid injections, medications, muscle relaxers, or physical therapy. MRI of the lumbar spine dated 01/25/11 revealed moderate facet arthropathy at L4-5 and L5-S1 with a disc protrusion present at L4-5 abutting the exiting nerve roots. The patient was seen by Dr. on 02/13/12 with continuing complaints of low back pain. Physical examination at this visit revealed positive straight leg raise to the left at 70 degrees with decreased sensation in the left posterior calf. Additional

epidural steroid injections were recommended. Follow up with Dr. on 03/19/12 stated the patient did not improve further with additional epidural steroid injections. No physical examination was performed at this visit. Clinical evaluation with Dr. dated 03/28/12 stated the patient had not improved further with medications or injections. The patient did report difficulty maintaining erections. Physical examination demonstrated positive straight leg raise bilaterally with loss of muscle strength in the left leg. Reflexes were symmetric at this visit. Follow up with Dr. on 05/09/12 stated patient's symptoms have not changed; however, the patient did report an increase in intensity. The patient reported paresthesia in the left lower extremity. Physical examination revealed a normal gait with no difficulty in standing. No reflex changes were present.

Follow up on 07/05/12 did not report any changes in the patient's pain symptoms. Electrodiagnostic studies were stated to show evidence of a left L5 and S1 radiculopathy; however, no electrodiagnostic studies reports were provided for review. The patient stated that his weakness in the left lower extremity had become worse. The physical examination revealed unchanged strength in the left lower extremity with normal muscle tone. His reflexes were equal and symmetric and sensation was intact in the lower extremities. The request for repeat MRI of the lumbar spine was denied by utilization review on 04/26/12 due to no clinical documentation regarding surgical intervention changes in symptoms or findings warranting further imaging studies. The request for repeat MRI of the lumbar spine was again denied by utilization review on 07/10/12 as the patient had no changes in symptoms or findings to support further imaging studies.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The guidelines recommend that repeat MRI studies be reserved for patients who demonstrate significant progressive or significant new or progressive neurological deficits that may signal pathology changes in the lumbar spine. The clinical documentation provided for this review demonstrates the patient has continuing complaints of pain in the left lower extremity with weakness. The patient's physical examinations continue to identify loss of strength in the left lower extremity; however, no significant changes in muscular tone, reflexes, or sensation was noted that would reasonably require new MRI studies under the guidelines. Given the lack of any objective findings to support a change in the patient's continually reported symptoms, the reviewer finds medical necessity does not exist at this time for Repeat Lumbar MRI.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- ☐ AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ☐ DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- ☒ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- ☒ ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)